HFS benefits

Please include this form for OTC medications purchased after 1/1/2011 or any dual purpose item that requires a letter of medical recommendation

This form should be completed by your physician. All fields in the appropriate section must be completed. Use additional sheets if necessary. Unless otherwise noted by your physician, this form will expire after 1 year.

Please provide the following information (please print clearly)

Employee Name: _____

Employee ID: _____

Employer Name: _____

☐ **Prescribed Over the Counter Medications**

List the specific prescribed over the counter medications:

_____

_____

_____

Physician Signature: _____ Date: _____

Print Name: _____ Phone: _____

Address: _____

☐ **Dual Purpose Items** (e.g. Massage Therapy, Weight Loss Programs, Nutritionist Expenses)

Describe the diagnosed condition being treated:

_____

_____

Describe the specific recommended treatment: If vitamins/supplements are being recommended, your physician must specify each individual supplement needed to treat the medical condition listed.

_____

_____

Indicate the duration of treatment:

_____

_____

This treatment is recommended to treat the medical condition referenced above. This treatment is not for general health purposes, to improve the appearance or for cosmetic services.

Physician Signature: _____ Date: _____

Print Name: _____ Phone: _____

Address: _____

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